DEPARTMENT OF PUBLIC HEALTH
AND HUMAN SERVICES

CHAPTER 88

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General Requirements

37.88.101 MEDICAID MENTAL HEALTH SERVICES, AUTHORIZATION REQUIREMENTS (1) Mental health services for a medicaid recipient under the Montana medicaid program will be reimbursed only if the following requirements are met:

(a) the recipient is a youth who has been determined to have a serious emotional disturbance as defined in ARM 37.86.3702;

(b) the department has determined prior to treatment on a case by case basis that treatment is medically necessary for early intervention and prevention of a more serious emotional disturbance;

(c) prior authorization has been obtained for outpatient therapy services that are provided concurrently with comprehensive school and community treatment (CSCT) program services described at ARM 37.106.1955, 37.106.1956, 37.106.1960, 37.106.1961, 37.106.1965 and 37.86.2225; or

(d) the recipient is 18 or more years of age and has been determined to have a severe disabling mental illness as defined in ARM 37.86.3502.

(2) For all mental health services provided to a medicaid recipient under the age of 18, prior authorization is not required for the first 24 sessions of an individual or family outpatient service in the state fiscal year. Limitations for outpatient services are set forth in the fee schedule dated July 1, 2005. This rule does not apply to a session with a physician for the purpose of medication management.

(3) For all mental health services provided to an adult medicaid recipient under the Montana medicaid program, prior authorization is not required for the first 16 visits in the 12-month period beginning July 1, 2003 and each 12-month period thereafter for outpatient mental health counseling services billed under Current Procedure Terminology 4th Edition (CPT4) codes 90804, 90806, 90810, 90812, 90846 and 90847 only.

(4) Adult intensive outpatient therapy services may be medically necessary for a person with safety and security needs who has demonstrated the ability and likelihood of benefit from continued outpatient therapy. The person must meet the requirements of (4)(a) or (b). The person must also meet the requirements of (4)(c). The person has:

(a) a DSM-IV diagnosis with a severity specifier of moderate or severe of mood disorder (293.83, 295.70, 296.2x, 296.3x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 296.90, 396.40); or

(b) a DSM-IV diagnosis borderline personality disorder (301.83), personality disorder (NOS) (301.9) with prominent features of 301.83; and

(c) ongoing difficulties in functioning because of mental illness for a period of at least six months or for an obviously predictable period over six months, as indicated by:

(i) dysregulation of emotion, cognition, behavior and interpersonal relationships;

(ii) resulting in recurrent suicidal, parasuicidal, serious self-damaging impulsive behaviors, or serious danger to others;

(iii) a history of treatment at a higher level of care, and

(iv) evidence that lower levels of care are inadequate to meet the needs of the client.

(5) The department may waive a requirement for prior authorization when the provider can document that:

(a) there was a clinical reason why the request for prior authorization could not be made at the required time; or

(b) a timely request for prior authorization was not possible because of a failure or malfunction of equipment that prevented the transmittal of the request at the required time.

(6) The prior authorization requirement shall not be waived except as provided in this rule.

(7) Under no circumstances may a waiver under (5) be granted more than 30 days after the initial date of service.

(8) Review of authorization requests by the department or its designee will be made with consideration of the clinical management guidelines (2004). A copy of the clinical management guidelines (2004) can be obtained from the department by a request in writing to the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 555 Fuller, P.O. Box 202905, Helena, MT 59620-2905, or to the Department of Public Health and Human Services, Health Resources Division, Children's Mental Health Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951 or can be viewed on the department's website at www.dphhs.mt.gov/aboutus/divisions/addictivementaldisorders/index.shtml.

(9) The department may review the medical necessity of services or items at any time either before or after payment in accordance with the provisions of ARM 37.85.410. If the department determines that services or items were not medically necessary or otherwise in compliance with applicable requirements, the department may deny payment or may recover any overpayment in accordance with applicable requirements.

(10) The department or its designee may require providers to report outcome data or measures regarding mental health services, as determined in consultation with providers and consumers. (History: 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195; EMERG, AMD, 2002 MAR p. 1328, Eff. 4/26/02; EMERG, AMD, 2002 MAR p. 3423, Eff. 12/13/02; EMERG, AMD, 2003 MAR p. 1087, Eff. 5/23/03; AMD, 2004 MAR p. 84, Eff. 1/1/04; AMD, 2004 MAR p. 1625, Eff. 6/4/04; AMD, 2005 MAR p. 1787, Eff. 9/23/05.)

Rules 02 through 09 reserved

37.88.110 TEMPORARY RATE ADJUSTMENT (1) There is an emergency reimbursement reduction in effect for the following provider types for medicaid mental health services provided January 11, 2002 through June 30, 2002:

(a) psychiatrists;

(b) psychologists;

(c) licensed social workers; and

(d) licensed professional counselors.

(2) The fee reduction will apply to the provider types listed in this rule both in private practice as well as those providing services through a licensed mental health center.

(3) The net pay reimbursement for provider types listed in this rule will be 2.6% less than the amount provided in ARM 37.85.212, 37.86.105, 37.88.206, 37.88.306 and 37.88.606.

(a) For purposes of this rule, "net pay reimbursement" means the allowed amount minus third party liability payments, copayments, coinsurance, incurments, and other deductions.

(4) If there are sufficient funds available as a result of these reductions at the end of state fiscal year 2002, the providers of services affected by this rule may be eligible for a rebate.

(5) If a rebate is to occur, the department will define a process for calculating and issuing the rebate. (History: Sec. 53-6-113 and 53-21-201, MCA; IMP, Sec. 53-6-101, 53-6-113 and 53-21-201, MCA; EMERG, NEW, 2002 MAR p. 1328, Eff. 4/26/02.)

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Subchapter 2

Licensed Clinical Social Work Services

37.88.201 LICENSED CLINICAL SOCIAL WORK SERVICES, DEFINITIONS (1) Licensed clinical social work services are those services provided by a licensed clinical social worker which are within the scope of practice permitted by Title 37, chapter 22, MCA, and covered under the provisions of these rules. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195.)

Rules 02 through 04 reserved

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37.88.205 LICENSED CLINICAL SOCIAL WORK SERVICES, REQUIREMENTS (1) These requirements are in addition to those contained in rule provisions generally applicable to medicaid providers.

(2) For purposes of medicaid coverage and reimbursement, licensed social work services are limited to the services designated in the department's Covered Social Work CPT Codes List (2004). The department adopts and incorporates by reference the Covered Social Work CPT Codes List (2004). A copy of the Covered Social Work CPT Codes List (2004) may be obtained from the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 555 Fuller, P.O. Box 202905, Helena, MT 59620-2905.

(3) Group therapy services provided by licensed clinical social worker must have no more than eight individuals participating in the group.

(4) When an eligible child receives licensed clinical social worker services and the provider consults with the parent as part of the child's treatment, the time with the parent may be billed to medicaid under the child's name, subject to the requirements of these rules. The provider shall indicate on the claim that the child is the patient and state the child's diagnosis. He shall also indicate consultation was with the parent.

(5) Licensed clinical social worker services must be supported by records as required in ARM 37.85.414.

(6) Services provided through interactive video systems are considered to be face-to-face services and are covered and reimbursed in the same fashion as in-person services. Telephone contacts are not a licensed clinical social worker service.

(7) Services that can be included under a facility's long term care per diem are not payable as licensed clinical social work services.

(8) Inpatient social work services provided in a hospital on an inpatient basis that are covered by medicaid as part of the diagnosis related group (DRG) payment under ARM 37.86.2907 are not reimbursable as licensed clinical social worker services. These noncovered services include:

(a) services provided by a licensed clinical social worker who is employed or under a contract with a hospital;

(b) services provided for purposes of discharge planning as required by 42 CFR, part 482.43; and

(c) services, including, but not limited to, group therapy, that are required as part of hospital licensure or certification. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195; AMD, 2004 MAR p. 482, Eff. 2/27/04.)

37.88.206 LICENSED CLINICAL SOCIAL WORK SERVICES, REIMBURSEMENT (1) Providers must bill for covered services using the procedure codes and modifiers set forth and according to the definitions contained in the health care financing administration's common procedure coding system (HCPCS). Information regarding billing codes, modifiers and HCPCS is available upon request from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) Subject to the requirements of this rule, the Montana medicaid program pays the following for licensed clinical social worker services:

(a) For patients who are eligible for medicaid, the lower of:

(i) the provider's usual and customary charge for the service; or

(ii) 62% of the reimbursement provided in accordance with the methodologies described in ARM 37.85.212. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01.)

Subchapter 3

Licensed Professional Counselor Services

37.88.301 LICENSED PROFESSIONAL COUNSELOR SERVICES, DEFINITIONS (1) Licensed professional counselor services are those services provided by a licensed professional counselor which are within the scope of practice permitted in Title 37, chapter 23, MCA and ARM Title 8, chapter 61, subchapter 12, and covered under the provisions of these rules. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195.)

Rules 02 through 04 reserved

37.88.305 LICENSED PROFESSIONAL COUNSELOR SERVICES, REQUIREMENTS (1) These requirements are in addition to those contained in rule provisions generally applicable to medicaid providers.

(2) For purposes of medicaid coverage and reimbursement, licensed professional counselor services are limited to the services designated in the department's Covered Licensed Professional Counselor CPT Codes List (2004). The department adopts and incorporates by reference the Covered Licensed Professional Counselor CPT Codes List (2004). A copy of the Covered Licensed Professional Counselor CPT Codes List (2004) may be obtained from the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 555 Fuller, P.O. Box 202905, Helena, MT 59620-2905.

(3) Licensed professional counselor group counseling services must have no more than eight individuals participating in the group.

(4) When an eligible child receives professional counselor services and the professional counselor consults with the parent as part of the child's treatment, the time with the parent may be billed to medicaid under the child's name, subject to the requirements of these rules. The provider shall indicate on the claim that the child is the patient and state the child's diagnosis. He shall also indicate consultation was with the parent.

(5) Licensed professional counselor services must be supported by records as required in ARM 37.85.414.

(6) Services provided through interactive video systems are considered to be face-to-face services and are covered and reimbursed in the same fashion as in-person services. Telephone contacts are not a professional counselor service.

(7) Services that can be included under a facility's long term care per diem are not payable as licensed professional counselor services.

(8) Inpatient professional counselor services provided in a hospital on an inpatient basis that are covered by medicaid as part of the diagnosis related group (DRG) payment under ARM 37.86.2907 are not reimbursable as licensed professional counselor services. These noncovered services include:

(a) services provided by a licensed professional counselor who is employed or under a contract with a hospital;

(b) services provided for purposes of discharge planning as required by 42 CFR 482.43; and

(c) services, including, but not limited to, group therapy, that are required as part of hospital licensure or certification. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 865; AMD, 2004 MAR p. 482, Eff. 2/27/04.)

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37.88.306 LICENSED PROFESSIONAL COUNSELOR SERVICES, REIMBURSEMENT (1) Providers must bill for covered services using the procedure codes and modifiers set forth, and according to the definitions contained, in the health care financing administration's common procedure coding system (HCPCS). Information regarding billing codes, modifiers and HCPCS is available upon request from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) Subject to the requirements of this rule, the Montana medicaid program pays the following for licensed professional counselor services:

(a) For patients who are eligible for medicaid, the lower of:

(i) the provider's usual and customary charge for the service; or

(ii) 62% of the reimbursement provided in accordance with the methodologies described in ARM 37.85.212. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 865; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01.)

Subchapters 4 and 5 reserved

Subchapter 6

Licensed Psychologist Services

37.88.601 LICENSED PSYCHOLOGIST SERVICES, DEFINITIONS

(1) Licensed psychologist services are those services provided by a licensed psychologist, which are within the scope of practice permitted by Title 37, chapter 17, MCA, and covered under the provisions of these rules. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195.)

Rules 02 through 04 reserved

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37.88.605 LICENSED PSYCHOLOGIST SERVICES, REQUIREMENTS

(1) These requirements are in addition to those contained in rule provisions generally applicable to medicaid providers.

(2) For purposes of medicaid coverage and reimbursement, licensed psychologist services are limited to the services designated in the department's Covered Psychologist CPT Codes List (2004). The department adopts and incorporates by reference the Covered Psychologist CPT Codes List (2004). A copy of the Covered Psychologist CPT Codes List (2004) may be obtained from the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 555 Fuller, P.O. Box 202905, Helena, MT 59620-2905.

(3) Group therapy services provided by a licensed psychologist must have no more than eight individuals participating in the group.

(4) When an eligible child receives licensed psychologist services, and the psychologist consults with the parent as part of the child's treatment, time spent with the parent may be billed to medicaid under the child's name, subject to the requirements of these rules. The provider shall indicate on the claim that the child is the patient and state the child's diagnosis. He shall also indicate consultation was with the parent.

(5) Licensed psychologist services must be supported by records as required in ARM 37.85.414.

(6) Services provided through interactive video systems are considered to be face-to-face services and are covered and reimbursed in the same fashion as in person services. Telephone contacts are not a licensed psychologist service.

(7) Licensed psychologist services provided in a hospital on an inpatient basis that are covered by medicaid as part of the diagnosis related group (DRG) payment under ARM 37.86.2907 are not reimbursable as psychological services. These noncovered services include:

(a) services provided by a licensed psychologist who is employed or under a contract with a hospital;

(b) services provided for purposes of discharge planning as required by 42 CFR, part 482.43; and

(c) services including, but not limited to, group therapy, that are required as a part of hospital licensure or certification. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195; AMD, 2004 MAR p. 482, Eff. 2/27/04.)

37.88.606 LICENSED PSYCHOLOGIST SERVICES, REIMBURSEMENT

(1) Providers must bill for covered services using the procedure codes and modifiers set forth and according to the definitions contained in the health care financing administration's common procedure coding system (HCPCS). Information regarding billing codes, modifiers and HCPCS is available upon request from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) Subject to the requirements of this rule, the Montana medicaid program pays the following for licensed psychologist services:

(a) For patients who are eligible for medicaid, the lower of:

(i) the provider's usual and customary charge for the service; or

(ii) 62% of the reimbursement provided in accordance with the methodologies described in ARM 37.85.212. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01.)

Subchapters 7 and 8 reserved

Subchapter 9

Mental Health Center Services

37.88.901 MENTAL HEALTH CENTER SERVICES, DEFINITIONS

(1) "Adult" means a person who is not a child or adolescent as defined in this rule.

(2) "Adult day treatment" means a program which provides, in accordance with mental health center license requirements, a variety of mental health services to adults with severe disabling mental illness.

(3) "Child or adolescent" means a person 17 years of age and younger or a person who is under 21 years of age and is enrolled in secondary school.

(4) "Child and adolescent day treatment" means a program which provides, in accordance with mental health center license requirements, an integrated set of mental health, education and family intervention services to children or adolescents with severe emotional disturbance.

(5) "Community based psychiatric rehabilitation and support" means services provided in home, school, workplace, and community settings for adults with severe and disabling mental illness and youth with serious emotional disturbance. Services are provided by trained mental health personnel under the direction of and according to individualized treatment plans prepared by licensed professionals. The services are provided outside of normal clinical or mental health program settings and are designed to assist individuals in developing the skills, behaviors, and emotional stability necessary to live successfully in the community. Community based psychiatric rehabilitation and support services are provided on a face-to-face basis with the recipient, family members, teachers, employers or other key individuals in the recipient's life when such contacts are clearly necessary to meet goals established in the recipient's individual treatment plan.

(a) Community based psychiatric rehabilitation and support includes but is not limited to the following services:

(i) evaluation and assessment of symptomatic, behavioral, social and environmental barriers to independent living and community integration;

(ii) assisting the consumer to develop communication skills, develop self-management of psychiatric symptoms, and develop social networks necessary to minimize social isolation and increase opportunities for a socially integrated life;

(iii) assisting the consumer to develop daily living skills and behaviors necessary for maintenance of a home and family, an appropriate education, employment or vocational situation, and productive leisure and social activities;

(iv) immediate intervention in a crisis situation and referral to necessary and appropriate care and treatment.

(b) Community based psychiatric rehabilitation and support does not include the following services:

(i) interventions provided in day treatment or partial hospitalization programs;

(ii) interventions provided in a hospital, nursing home or residential treatment facility;

(iii) interventions provided by staff of crisis facilities, group homes or therapeutic foster care providers in such facilities, homes or settings;

(iv) services provided as part of the recipient's intensive case management plan;

(v) therapeutic interventions by licensed practitioners, regardless of the location of the service;

(vi) activities which are purely recreational in nature; and

(vii) services provided within the school classroom that are educational, including, but not limited to educational aides.

(6) "Community mental health center" means a licensed mental health center, governed by a regional mental health corporation board created by 53-21-204, MCA, that provides the comprehensive mental health services listed in 53-21-201(1), MCA.

(7) "Crisis intervention services" means a program which provides, in accordance with mental health center license requirements, emergency short term 24-hour care, treatment and supervision in a crisis intervention stabilization facility for persons age 18 or older with mental illness experiencing a mental health crisis.

(8) "Day treatment services" means adult day treatment services and child and adolescent day treatment services.

(9) "Intensive community based rehabilitation facility" means an adult mental health group home that provides medically necessary rehabilitation services to adults with severe and disabling mental illness who have a history of institutional placements due to mental illness and a history of repeated unsuccessful placements in less intensive community based programs. The provider must provide the following services to residents:

(a) close supervision and support of daily living activities;

(b) assistance with medications including administration of medications as necessary;

(c) rehabilitation in the following areas as needed by each client:

(i) maintenance of physical health and wellness;

(ii) personal hygiene;

(iii) safety;

(iv) symptom management;

(v) communication skills;

(vi) vocational activities;

(vii) community integration;

(viii) social skills;

(ix) leisure and recreation skills;

(x) establishment and maintenance of a community support network;

(xi) establishment and maintenance of meaningful daily structure; and

(xii) management of personal finances;

(d) case management to assure all necessary community services and supports, including services and supports for non-psychiatric medical conditions, are available;

(e) discharge planning for transition to a less restrictive setting when appropriate; and

(f) transportation to assure appropriate community resources are accessible.

(10) "Foster care for mentally ill adults" means a supervised living environment in a licensed foster home with support services by mental health professionals.

(11) "In-training practitioner services" are services provided under the supervision of a licensed practitioner by an individual who has completed all academic requirements for licensure as a psychologist, clinical social worker or licensed professional counselor and is in the process of completing the supervised experience requirement for licensure. The in-training practitioner's services must be supervised by a licensed practitioner in the same field, and, other than licensure, the services are subject to the same requirements that apply to licensed practitioners.

(12) "Mental health center services" means child and adolescent day treatment services, adult day treatment services, community based psychiatric rehabilitation and support respite care, in-training practitioner services and the therapeutic component of crisis intervention services, foster care for mentally ill adults and mental health group home services and programs of assertive community treatment, as defined in these rules.

(13) "Mental health group home services" means a supported living environment provided under a group home endorsed mental health center license and providing independent living and social skills development services.

(14) "Program of assertive community treatment" means a self-contained clinical team which:

(a) provides needed treatment, rehabilitation and support services to identified clients with severe disabling mental illness;

(b) minimally refers clients to outside service providers;

(c) provides services on a long term basis;

(d) delivers 75% or more of team service time outside program offices;

(e) serves individuals with severe disabling mental illness (SDMI) who are at least 18 years old, have severe symptoms and impairments not effectively treated by other available, less intensive services, or who have a history of avoiding mental health services;

(f) provides psychiatric services at the rate of at least 20 hours per week for each 70 persons served; and

(g) maintains a ratio of at least one staff person, not including the psychiatrist, for each nine persons served. Assertive community treatment teams must be approved by the addictive and mental disorders division.

(15) "Practitioner" means a physician, mid-level practitioner, licensed psychologist, licensed clinical social worker or licensed professional counselor.

(16) "Practitioner services" means services provided by a practitioner which could be covered and reimbursed by the Montana medicaid program if the individual practitioner were enrolled in the program and provided the services according to applicable medicaid requirements.

(17) "Respite care" means relief services that allow family members, who are regular care givers for an adult with severe disabling mental illness or a youth with serious emotional disturbance, to be relieved of their care giver responsibilities for a temporary, short term period.

(18) "Treatment day" means a calendar day, including night, daytime or evening, during which a patient is present at the provider's facility and receiving services according to applicable requirements. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195; AMD, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2002 MAR p. 2225, Eff. 8/16/02; AMD, 2004 MAR p. 84, Eff. 1/1/04.)

Rules 02 through 04 reserved

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37.88.905 MENTAL HEALTH CENTER SERVICES, REQUIREMENTS

(1) These requirements are in addition to those requirements contained in rules generally applicable to medicaid providers.

(2) Mental health center services may be provided only by a facility which is licensed as a mental health center by the department in accordance with the provisions of Title 50, chapter 5, part 2, MCA, and implementing administrative rules.

(3) Mental health center services must be provided by, or under the direction of a licensed physician.

(4) Mental health center services must be available to recipients continuously throughout the year.

(5) Mental health center services must be provided to a recipient in accordance with an individualized treatment plan developed and maintained in accordance with license requirements.

(6) In addition to the clinical records required by mental health center license rules, the provider must maintain for day treatment services the records required by ARM 37.85.414, which shall include but are not limited to documentation of the recipient's attendance for the required period of time for the service billed and entry of progress notes in the recipient's record at least every 30 days and upon any significant change in the recipient's condition.

(7) For purposes of medicaid billing and reimbursement of day treatment services, a half day requires that the recipient has attended the day treatment program for a minimum of two hours during the treatment day.

(8) For purposes of meeting the minimum hours required in (7), the provider may not include time during which the recipient is receiving practitioner services which are actually billed separately as practitioner services as permitted under ARM 37.88.906, up to a maximum of four hours during the treatment day.

(9) Services billed as community-based psychiatric rehabilitation and support may not be counted toward the time requirements for any other service or billed by the provider as any other type or category of service. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195; AMD, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2002 MAR p. 2225, Eff. 8/16/02.)

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37.88.906 MENTAL HEALTH CENTER SERVICES, COVERED SERVICES

(1) Mental health center services, covered by the medicaid program, include the following:

(a) adult half-day day treatment services;

(b) child and adolescent day treatment services;

(c) community based psychiatric rehabilitation and support;

(d) program of assertive community treatment;

(e) respite care services;

(f) in-training practitioner services; and

(g) the therapeutic component of:

(i) crisis intervention services;

(ii) foster care for mentally ill adults; and

(iii) mental health adult group home services.

(2) The therapeutic component of crisis intervention services includes all crisis intervention services provided by the mental health center and, except as provided in (4)(a), its staff, but does not include room and board.

(3) A mental health center may provide case management services for youth with serious emotional disturbance and adults with severe disabling mental illness if enrolled as a provider of such services and in accordance with the requirement of medicaid rules applicable to those service categories. Case management services will be reimbursed only to the extent allowable and according to the medicaid rules applicable to the particular category of service.

(4) Mental health center services do not include practitioner services, except as specifically provided by and in accordance with the requirements of these rules. Except as provided by these rules, practitioner services may be covered and reimbursed by medicaid only if the practitioner is enrolled as a provider and according to the medicaid rules and requirements applicable to the practitioner's category of service.

(a) Mental health center services may include practitioner services provided according to mental health center license requirements as part of mental health center services. To the extent otherwise permitted by applicable medicaid rules, such practitioner services may be billed by the mental health center either as mental health center services or by the practitioner under the applicable medicaid category of service, but may not be billed as both mental health center services and practitioner services.

(b) Mental health center services, covered by the medicaid program, include the medical director component of a physician's services to the mental health center, but do not include the professional component of physician services covered in ARM 37.86.101, 37.86.104 and 37.86.105. The professional component of physician services may be billed according to the provisions of (4)(a) or ARM 37.86.101, 37.86.104 and 37.86.105.

(5) To the extent provided as part of mental health center services in accordance with (4)(a):

(a) family counseling is covered as a mental health center service only if medically necessary for the treatment of the medicaid eligible family member who is involved in the family therapy; and

(b) individual therapy includes diagnostic interviews where testing instruments are not used.

(6) Practitioner services provided in a hospital on an inpatient basis that are covered by medicaid as part of the diagnosis related group (DRG) payment under ARM 37.86.2907 are not reimbursable as mental health center services. These noncovered services include:

(a) practitioner services provided by practitioners who are staff of a mental health center which has a contract with a hospital involving consideration;

(b) services provided for purposes of discharge planning as required by 42 CFR Part 482.43; and

(c) services including but not limited to group therapy, that are required as a part of hospital licensure or certification. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195; AMD, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2002 MAR p. 2225, Eff. 8/16/02; AMD, 2004 MAR p. 482, Eff. 2/27/04.)

37.88.907 MENTAL HEALTH CENTER SERVICES, REIMBURSEMENT

(1) Medicaid reimbursement for mental health center services shall be the lowest of:

(a) the provider's actual (submitted) charge for the service;

(b) the department's medicaid fee for the service as specified in the department's medicaid mental health fee schedule.

(2) For day treatment and crisis intervention services, medicaid will not reimburse a mental health center provider for more than one fee per treatment day per recipient. This does not apply to practitioner services to the extent such services are separately billed in accordance with these rules.

(3) Reimbursement will be made to a provider for reserving an adult foster care or mental health adult group home bed only if:

(a) the recipient's plan of care documents the medical need for a therapeutic visit as part of a therapeutic plan;

(b) the recipient is temporarily absent on a therapeutic visit;

(c) the provider clearly documents staff contact and recipient achievements or regressions during and following the therapeutic visit; and

(d) no more than 14 patient days per recipient in each rate year will be reimbursed for therapeutic visits. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195; AMD, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01; AMD, 2002 MAR p. 1328, Eff. 4/26/02; AMD, 2004 MAR p. 84, Eff. 1/1/04.)

Rules 08 and 09 reserved

NEXT PAGE IS 37-21685

37.88.910 RESIDENTIAL PSYCHIATRIC CARE OUTSIDE MONTANA

(1) Payment for inpatient psychiatric services provided outside the state of Montana will be made only under the conditions specified in ARM 37.85.207(3) and these rules. The Montana medicaid program will not make payment according to ARM 37.85.207(3)(b) or (c) for inpatient psychiatric services provided by residential treatment facilities located outside the state of Montana unless the department or its designee determines, as provided in this rule, that the services were unavailable in the state of Montana.

(2) Residential psychiatric care will not be determined to be unavailable in the state of Montana unless:

(a) the recipient has been officially screened for placement by all enrolled in-state residential treatment facility providers and denied admission because the facilities cannot meet the recipient's treatment needs; or

(b) the recipient has been officially screened for placement by all enrolled in-state residential treatment facility providers and denied admission because a bed is not available, and the recipient's psychiatric condition prevents the recipient from being temporarily and safely placed in another setting while awaiting placement in an in-state residential treatment facility.

(3) The department or its designee will not commence a preadmission review for or certify an admission to an out-of-state residential treatment facility until receiving from the prospective facility written verification that the recipient cannot be served within the state of Montana. Written verification must be provided in a form approved by the department or its designee, and must be completed and signed on behalf of in-state facilities indicating that the requirements of (2)(a) or (2)(b) are met. In-state facilities that do not complete, sign and return the form by fax to the prospective out-of-state provider within three days after receipt will be deemed to be unable to serve the recipient. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04.)

Subchapter 10 reserved

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Subchapter 11

Inpatient Psychiatric Services

37.88.1101 INPATIENT PSYCHIATRIC SERVICES, PURPOSE

(1) The purpose of ARM 37.88.1101, 37.88.1105, 37.88.1106, 37.88.1107, 37.88.1110, 37.88.1115 and 37.88.1116 is to specify provider participation and program requirements and to define the basis and procedure the department will use to pay for inpatient psychiatric services for individuals under age 21. Facilities in which these services are available are referred to as providers. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195; AMD, 2001 MAR p. 989, Eff. 6/8/01; AMD, 2004 MAR p. 1328, Eff. 6/4/04.)

37.88.1102 INPATIENT PSYCHIATRIC SERVICES, DEFINITIONS As used in this subchapter, the following definitions apply:

(1) "Continuity of care payment" means an annual payment made to qualifying hospital based residential treatment facilities according to the eligibility criteria and payment calculation methodology in ARM 37.88.1137.

(2) "Devoted to the provision of inpatient psychiatric care for persons under the age of 21" means an inpatient psychiatric hospital facility or residential treatment facility whose goals, purpose and care are designed for and devoted exclusively to persons under the age of 21.

(3) "Hospital based residential psychiatric care" means residential psychiatric care that is provided in a hospital based residential treatment facility.

(4) "Hospital based residential treatment facility" means a residential treatment facility that meets the requirements of ARM 37.88.1131.

(5) "Inpatient hospital psychiatric care" means hospital based active psychiatric treatment provided under the direction of a physician.

(6) "Inpatient psychiatric hospital facility" means a psychiatric facility devoted to the provision of inpatient psychiatric care for persons under the age of 21 licensed as a hospital by:

(a) the department; or

(b) an equivalent agency in the state in which the facility is located.

(7) "Inpatient psychiatric services" means inpatient hospital psychiatric care, residential psychiatric care, or hospital based residential psychiatric care.

(8) "Patient day" means a whole 24-hour period in which a person is present and receiving inpatient psychiatric services. Even though a person may not be present for a whole 24-hour period, the day of admission and, subject to the limitations and requirements of ARM 37.88.1106, therapeutic home leave days are patient days. The day of discharge is not a patient day for purposes of reimbursement.

(9) "Residential psychiatric care" means active psychiatric treatment provided in a residential treatment facility to psychiatrically impaired individuals with persistent patterns of emotional, psychological or behavioral dysfunction of such severity as to require 24-hour supervised care to adequately treat or remediate their condition.

(10) "Residential treatment facility" means a psychiatric facility devoted to the provision of inpatient psychiatric care for persons under the age of 21 licensed by:

(a) the department as a residential treatment facility, or;

(b) the appropriate agency as a residential treatment facility or the equivalent in the state where the facility is located. (History: Sec. 2-4-201, 53-2-201 and 53-6-113, MCA; IMP, Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-149, MCA; NEW, 2004 MAR p. 1328, Eff. 6/4/04.)

Rules 03 and 04 reserved

37.88.1105 INPATIENT PSYCHIATRIC SERVICES, PARTICIPATION REQUIREMENTS (1) These requirements are in addition to those contained in rule provisions generally applicable to medicaid providers.

(2) Inpatient psychiatric service providers, as a condition of participation in the Montana medicaid program, must comply with the following requirements:

(a) maintain a current license as a hospital or a residential treatment facility under the rules of the department's quality assurance division to provide inpatient hospital psychiatric care or residential psychiatric care, or, if the provider's facility is not located within the state of Montana, maintain a current license in the equivalent category under the laws of the state in which the facility is located;

(b) maintain a current certification for Montana medicaid under the rules of the department's quality assurance division to provide inpatient hospital psychiatric care or residential psychiatric care or, if the provider's facility is not located within the state of Montana, meet the requirements of (2)(g) and (2)(h);

(c) for all providers, enter into and maintain a current provider enrollment form with the department's fiscal agent to provide inpatient psychiatric treatment services;

(d) license and/or register facility personnel in accordance with applicable state and federal laws;

(e) accept, as payment in full for all operating and property costs, the amounts paid in accordance with the reimbursement method set forth in these rules;

(f) for providers maintaining patient trust accounts, insure that any funds maintained in those accounts are used only for those purposes for which the patient, legal guardian or personal representative of the patient has given written authorization. A provider may not borrow funds from these accounts for any purpose;

(g) for hospital providers:

(i) comply with 42 CFR sections 482.1 through 482.62 and meet the requirements of section 1861(f) of the Social Security Act, which are federal regulations and statutes setting forth requirements for psychiatric hospitals. The department hereby adopts and incorporates herein by reference the above-cited regulations and statutes. Copies of these regulations and statutes may be obtained from the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 1400 Broadway. P.O. Box 202951, Helena, MT 59620-2951; or

(ii) be accredited by the joint commission on accreditation of health care organizations (JCAHCO) or any other organization designated by the secretary of the United States department of health and human services as authorized to accredit psychiatric hospitals for medicaid participation.

(h) maintain accreditation as a residential treatment facility by the joint commission on accreditation of health care organizations (JCAHCO) or any other organization designated by the secretary of the United States department of health and human services as authorized to accredit residential treatment facilities for medicaid participation;

(i) submit to the department prior to receiving initial reimbursement payments and thereafter within 30 days after receipt, all accreditation determinations, findings, reports and related documents issued by the accrediting organization to the provider;

(j) provide inpatient psychiatric services according to the service requirements for individuals under age 21 specified in Title 42 CFR, Part 441, subpart D (1997), which is a federal regulation which is herein incorporated by reference. A copy of these regulations may be obtained through the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951;

(k) agree to indemnify the department in the full amount of the state and federal shares of all medicaid inpatient psychiatric services reimbursement paid to the facility during any period when federal financial participation is unavailable due to facility failure to meet the conditions of participation specified in these rules or due to other facility deficiencies or errors. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195.)

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37.88.1106 INPATIENT PSYCHIATRIC SERVICES, REIMBURSEMENT

(1) For inpatient psychiatric services provided on or after July 1, 1999, the Montana medicaid program will pay a provider for each patient day as provided in these rules.

(a) Medicaid payment is not allowable for treatment or services provided in a residential treatment facility that are not within the definition of residential psychiatric care in ARM 37.88.1102 and all other applicable requirements are met.

(b) Medicaid payment is not allowable for treatment or services provided in an inpatient psychiatric hospital facility that are not within the definition of inpatient hospital psychiatric care in ARM 37.88.1102 and unless all other applicable requirements are met.

(2) For inpatient psychiatric services provided by a residential treatment facility in the state of Montana, the Montana medicaid program will pay a provider, for each medicaid patient day, a bundled per diem rate as specified in (3), less any third party or other payments.

(3) The statewide bundled per diem rate for inpatient psychiatric services is the lesser of:

(a) the amount specified in the department's medicaid mental health fee schedule; or

(b) the provider's usual and customary charges (billed charges).

(4) Reimbursement for inpatient psychiatric services provided to Montana medicaid recipients in facilities located outside the state of Montana will be as provided in ARM 37.86.2905. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195; AMD, 2001 MAR p. 2001, Eff. 1/12/01; EMERG, AMD, 2001 MAR p. 989, Eff. 6/8/01; AMD, 2002 MAR p. 1328, Eff. 4/26/02; EMERG, AMD, 2003 MAR p. 1087, Eff. 5/23/03; AMD, 2004 MAR p. 1328, Eff. 6/4/04.)

37.88.1107 INPATIENT PSYCHIATRIC SERVICES, COST SETTLEMENT AND UNDERPAYMENT (1) For facilities located outside the state of Montana, the department may, as provided in (2), perform cost settlements and correct overpayments and underpayments in accordance with the provisions of ARM 37.86.2801.

(2) The department may determine, through the cost settlement process, whether overpayments or underpayments have resulted to out-of-state providers receiving Montana medicaid reimbursements in excess of $50,000 per year. Where the department performs a cost settlement for an out-of-state facility, the provisions of ARM 37.86.2801 shall apply. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195.)

Rules 08 and 09 reserved

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37.88.1110 SERVICE ACCESS RATE ADJUSTMENT PAYMENT, ELIGIBILITY AND COMPUTATION (1) Subject to the availability of sufficient county and federal funding, the department will pay, in addition to the established medicaid rates provided in ARM 37.88.907, a service access rate adjustment payment to an eligible community mental health center in Montana as defined at 53-21-201, MCA when:

(a) the community mental health center's usual and customary (billed) charges are greater than the reimbursement received from Montana medicaid; and

(b) the community mental health center is funded, or partially funded, including tax district funding, by a county with fewer than six residents per square mile based on the latest population data published by the United States bureau of the census; and

(c) the community mental health center is reimbursed under Montana medicaid; and

(d) county funds are transferred directly to the department and are certified by the contributing county as match for payment of services eligible for federal financial participation in accordance with 42 CFR 433.51. The county funds shall not be federal funds or shall be federal funds authorized by federal law to be used to match other federal funds; and

(e) the community mental health center has executed and entered into a written agreement with the department concerning rural access to services and the provision of telephone crisis services and has agreed to abide by the terms of the written agreement.

(i) The written agreement between the department and the community mental health center must be executed prior to the issuance of the service access rate adjustment payment.

(ii) A community mental health center that does not enter into a written agreement with the department or does not abide by the terms of the agreement will not be eligible for the service access rate adjustment payment process.

(2) The department will calculate the amount of the service access rate adjustment payment for each eligible community mental health center using paid claims data from the community mental health center established pursuant to 53-21-204, MCA, for the quarter ending one quarter before the quarter in which the service access rate adjustment payment will be paid. The service access rate adjustment payment for each eligible community mental health center shall be the least of:

(a) the difference between the community mental health center's usual and customary (billed) charges and the reimbursement received from Montana medicaid;

(b) the amount of county funds transferred to the department and any state funds the department chooses to use for this purpose plus federal financial participation; or

(c) a premium over the established rates determined by the department but not to exceed 25%.

(3) No aggregate rate of medicaid reimbursement, including established medicaid rate and service access rate adjustment payments, for all community mental health centers shall exceed the corresponding medicare rate, if any.

(4) For the community mental health centers eligible for the service access rate adjustment payment, the department will pay the service access rate adjustment payment quarterly beginning July 1, 2001.

(5) The department shall include all service access rate adjustment payments in the department's quarterly reports as required by federal law and regulations.

(6) The service access rate adjustment payment is subject to the restrictions imposed by federal law. (History: Sec. 53-6-113 and 53-21-201, MCA; IMP, Sec. 53-6-101, 53-6-113 and 53-21-201, MCA; NEW, 2002 MAR p. 1328, Eff. 4/26/02; EMERG, AMD, 2003 MAR p. 1087, Eff. 5/23/03.)

Rules 11 through 14 reserved

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37.88.1115 INPATIENT PSYCHIATRIC SERVICES, ADMINISTRATIVE REVIEW AND FAIR HEARING PROCEDURES (1) The right to administrative review and fair hearing shall be in accordance with the provisions of ARM 46.12.509A. (History: Sec. 2-4-201 and 53-6-113, MCA; IMP, Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195.)

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37.88.1116 INPATIENT PSYCHIATRIC SERVICES, CERTIFICATION OF NEED FOR SERVICES, UTILIZATION REVIEW AND INSPECTIONS OF CARE

(1) Prior to admission and as frequently as the department may deem necessary, the department or its agents may evaluate the medical necessity and quality of services for each medicaid recipient.

(a) In addition to the other requirements of these rules, the provider must provide to the department or its agent upon request any records related to services or items provided to a medicaid recipient.

(b) The department may contract with and designate public or private agencies or entities or, a combination of public and private agencies and entities, to perform utilization review, inspections of care and other functions under this rule as an agent of the department.

(2) The department or its agents may conduct periodic inspections of care in residential treatment facilities participating in the medicaid program.

(3) Medicaid reimbursement is not available for inpatient psychiatric services unless the provider submits to the department or its designee in accordance with these rules a complete and accurate certificate of need for services that complies with the requirements of 42 CFR, Part 441, subpart D and these rules.

(a) For recipients determined medicaid eligible by the department as of the time of admission to the facility, the certificate of need must:

(i) be completed, signed and dated prior to, but no more than 30 days before admission; and

(ii) be made by an independent team of health care professionals that has competence in diagnosis and treatment of mental illness and that has knowledge of the recipient's situation, including the recipient's psychiatric condition. The team must include a physician that has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, a licensed mental health professional and, for residential psychiatric care, an intensive case manager employed by a mental health center.

(b) For recipients who are transferred between levels of inpatient psychiatric care within the same facility, the certificate of need may be completed by the facility-based team responsible for the plan of care within 14 days after admission provided that the:

(i) certificate of need has been signed by an intensive case manager employed by a mental health center or other individual knowledgeable about local mental health services as designated by the department; and

(ii) admission has been prior authorized by the department or the department's designee.

(c) For recipients determined medicaid eligible by the department after admission to or discharge from the facility, the certificate of need must:

(i) be completed, signed and dated within:

(A) 14 days after the eligibility determination for recipients determined eligible during the stay in the facility; or

(B) 90 days after the eligibility determination for recipients determined eligible after discharge from the facility;

(ii) cover the recipient's stay from admission through the date the certification is completed; and

(iii) be made by the facility team responsible for the recipient's plan of care as specified in 42 CFR, 441.155 and 441.156.

(d) All certificates of need must actually and personally be signed by each team member, except that signature stamps may be used if the team member actually and personally initials the document over the signature stamp.

(4) An authorization by the department or its utilization review agent under this rule is not a final or conclusive determination of medical necessity and does not prevent the department or its agents from evaluating or determining the medical necessity of services or items at any time. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195; AMD, 2001 MAR p. 27, Eff. 1/12/01.)

Rules 17 and 18 reserved

37.88.1119 INPATIENT HOSPITAL PSYCHIATRIC CARE

(1) Inpatient hospital psychiatric care is the briefest possible inpatient hospital stay necessary to provide the intensive psychiatric intervention and stabilization required to evaluate and/or stabilize the individual for discharge to the least restrictive appropriate setting for continuing care and treatment of the individual's psychiatric condition.

(2) The therapeutic intervention or evaluation must be designed to achieve the patient's discharge from inpatient hospital status to a less restrictive environment at the earliest possible time.

(3) The individual's psychiatric condition must be of such a nature as to pose a significant danger to self, others or the public safety. (History: Sec. 2-4-201, 53-2-201 and 53-6-113, MCA; IMP, Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 2004 MAR p. 1328, Eff. 6/4/04.)

Rule 20 reserved

37.88.1121 INPATIENT PSYCHIATRIC SERVICES (1) Inpatient psychiatric services are services that comply with the requirements of this subchapter and the applicable federal regulations and are provided in an inpatient psychiatric hospital facility or residential treatment facility that is devoted to the provision of inpatient psychiatric care for persons under the age of 21.

(2) 42 CFR 440.160 and 441.150 through 441.156 (1997), provide definitions and program requirements and are adopted and incorporated by reference. A copy of the regulations may be obtained through the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 555 Fuller, P.O. Box 202905, Helena, MT 59620-2905. (History: Sec. 2-4-201, 53-2-201 and 53-6-113, MCA; IMP, Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 2004 MAR p. 1328, Eff. 6/4/04.)

Rules 22 through 24 reserved

37.88.1125 INPATIENT PSYCHIATRIC HOSPITALS, REIMBURSEMENT

(1) For inpatient psychiatric services provided by inpatient psychiatric hospital facilities located in the state of Montana, the Montana medicaid program will pay a provider according to the diagnosis related groups (DRG) prospective payment system described in ARM 37.86.2905. In addition to the prospective DRG rate, providers will be reimbursed for the following:

(a) capital-related costs;

(b) cost or day outliers;

(c) catastrophic case payments;

(d) disproportionate share hospital (DSH) payments and supplemental DSH payments; and

(e) hospital reimbursement adjustor payments.

(2) Inpatient psychiatric hospital facilities will not be reimbursed for inpatient psychiatric services in addition to the prospective DRG rate for medical education costs, certified registered nurse anesthetist costs or other costs or components. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 2004 MAR p. 1328, Eff. 6/4/04.)

Rules 26 through 28 reserved

37.88.1129 RESIDENTIAL PSYCHIATRIC CARE (1) Residential psychiatric care must be individualized and designed to achieve the patient's discharge to a less restrictive level of care at the earliest possible time.

(2) Residential psychiatric care includes only treatment or services provided in accordance with all applicable licensure, certification and accreditation requirements and these rules.

(3) Residential psychiatric care must be provided under the direction of a licensed physician. (History: Sec. 2-4-201, 53-2-201 and 53-6-113, MCA; IMP, Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 2004 MAR p. 1328, Eff. 6/4/04.)

Rule 30 reserved

37.88.1131 HOSPITAL BASED RESIDENTIAL TREATMENT CENTERS, REQUIREMENTS (1) A hospital based residential treatment facility must meet the following requirements:

(a) the residential treatment facility must be in a hospital facility that includes inpatient psychiatric hospital beds and provides inpatient hospital psychiatric care to individuals under 21. The residential treatment facility beds and the hospital beds must be owned and operated by a single entity, and they must be located in an integrated facility;

(b) the residential treatment facility must be located in Montana;

(c) the inpatient psychiatric hospital beds and the residential treatment facility beds must be served by a common administrative and support staff;

(d) the residential treatment facility must be served by no less than one full-time equivalent psychiatrist for every 25 patients;

(e) both the hospital and the residential treatment facility must have an organized medical staff that is on call and available within 20 minutes, 24 hours a day, seven days a week; and

(f) both the hospital and the residential treatment facility must have 24-hour nursing care by licensed registered nurses. (History: Sec. 2-4-201, 53-2-201 and 53-6-113, MCA; IMP, Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 2004 MAR p. 1328, Eff. 6/4/04.)

Rule 32 reserved

37.88.1133 RESIDENTIAL TREATMENT CENTERS, REIMBURSEMENT

(1) The rate provided in the department's mental health fee schedule for residential treatment facility providers located in the state of Montana is the final rate, and such rate will not be adjusted retrospectively based upon more recent cost data or inflation estimates. Cost settlements will not be performed.

(2) The rate is an all-inclusive bundled rate.

(3) Except as provided otherwise in this rule, the per diem payment rate covers and includes:

(a) all psychiatric services;

(b) all therapies required in the recipient's plan of care;

(c) all other services and items related to the psychiatric condition being treated that are provided while the recipient is admitted to the residential treatment facility;

(d) services provided by licensed psychologists, licensed clinical social workers, and licensed professional counselors; and

(e) lab and pharmacy services.

(4) These services must be reimbursed from the provider's all-inclusive rate except as provided otherwise in this rule, and are not separately billable.

(5) The professional component of physician services is separately billable according to the applicable rules governing billing for physician services.

(6) Services and items that are not related to the recipient's psychiatric condition being treated in the residential treatment facility and that are not provided by the residential treatment facility are separately billable in accordance with the applicable rules governing billing for the category of services or items.

(7) Reimbursement will be made to a residential treatment facility provider for reserving a bed while the recipient is temporarily absent only if:

(a) the recipient's plan of care documents the medical need for therapeutic home visits as part of a therapeutic plan to transition the recipient to a less restrictive level of care;

(b) the recipient is temporarily absent on a therapeutic home visit;

(c) the provider clearly documents staff contact and recipient achievements or regressions during and following the therapeutic home visit; and

(d) the recipient is absent from the provider's facility for no more than three patient days per absence.

(8) No more than 14 patient days per recipient in each rate year will be allowed for therapeutic home visits.

(9) Providers must bill for inpatient psychiatric services using the revenue codes designated by the department. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 2004 MAR p. 1328, Eff. 6/4/04.)

Rules 34 through 36 reserved

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37.88.1137 RESIDENTIAL TREATMENT CENTERS, CONTINUITY OF CARE PAYMENT (1) Hospital based residential treatment facilities as defined in ARM 37.88.1131 qualify for a continuity of care payment.

(a) The amount of the continuity of care adjustor payment will be calculated and paid annually.

(b) The amount will be determined by the department according to the following formula: CCA=[M/D]*P:

(i) "CCA" represents the calculated continuity of care payment;

(ii) "M" is the number of medicaid inpatient residential days provided by the facility for which the continuity of care payment is being calculated;

(iii) "D" is the total number of medicaid inpatient residential days provided by all eligible facilities; and

(iv) "P" is the total amount available for distribution via the continuity of care payments. P equals 4% of the revenue generated by the Montana hospital utilization fee, plus federal financial participation.

(2) The number of medicaid days shall be determined from the department's medicaid paid claim data for the most recent calendar year that ended at least 12 months prior to the calculation of the continuity of care payment. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-149, MCA; NEW, 2004 MAR p. 1328, Eff. 6/4/04.)

Subchapters 12 and 13 reserved

Subchapter 14

Institutions for Mental Diseases

37.88.1401 INSTITUTIONS FOR MENTAL DISEASES, PURPOSE

(1) ARM 37.88.1401, 37.88.1402, 37.88.1405, 37.88.1406, 37.88.1410, 37.88.1411 and 37.88.1420 specify requirements for the provision of and reimbursement for medicaid nursing facility and hospital services to medicaid recipients who are residents of an institution for mental diseases. These rules are in addition to requirements generally applicable to medicaid providers as otherwise provided in state and federal statutes, rules, regulations and policies. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195; AMD, 2000 MAR p. 2036, Eff. 7/28/00.)

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37.88.1402 INSTITUTIONS FOR MENTAL DISEASES, DEFINITIONS

In ARM 37.88.1401, 37.88.1402, 37.88.1405, 37.88.1406, 37.88.1410, 37.88.1411 and 37.88.1420 the following definitions apply:

(1) "Department" means the Montana department of public health and human services or its agents, including but not limited to parties under contract to perform audit services, claim processing and utilization review.

(2) "Devoted to the provision of inpatient psychiatric hospital care to adults" means an institution for mental disease which is licensed and certified as a hospital and whose goals, purpose and care are designed for and devoted exclusively to providing diagnosis, treatment or care to persons with mental diseases age 18 and older.

(3) "Hospital" means a facility licensed, accredited or approved under the laws of Montana or a facility operated as a hospital by the state that provides, by or under the supervision of licensed physicians, services for the diagnosis, treatment, rehabilitation and care of persons with mental diseases.

(4) "Institution for mental diseases" means a hospital, nursing facility, or other institution with more than 16 beds which the department has determined is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. An institution for the mentally retarded, including an intermediate care facility for the mentally retarded, is not an institution for mental diseases.

(a) An institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

(i) In making a determination of whether an institution is an institution for mental diseases, the department shall consider the guidelines set forth in subsection C of section 4390 of the state medicaid manual, but no single guideline or combination of guidelines shall necessarily be determinative. The state medicaid manual is promulgated by the federal health care financing administration to provide guidance to states on administration of the medicaid program. The department hereby adopts and incorporates herein by reference subsection C of section 4390 of the state medicaid manual (1994). A copy of subsection C of section 4390 of the state medicaid manual may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(5) "Medicaid recipient" means a person who is eligible and receiving assistance under Title XIX of the Social Security Act for nursing facility services.

(6) "Mental disease" means a disease listed as a mental disorder in the current edition of the Diagnostic and Statistical Manual of Mental Diseases but does not include mental retardation, senility and organic brain syndrome.

(7) "Nursing facility services" means services defined in ARM 37.40.302, but not including intermediate care facility services for the mentally retarded.

(8) "Patient contribution" means the total of all of a resident's income from any source available to pay the cost of care, less the resident's personal needs allowance. The patient contribution includes a resident's incurment determined in accordance with applicable eligibility rules.

(9) "Patient day" means a whole 24-hour period that a person is present and receiving nursing facility services, regardless of the payment source. Even though a person may not be present for a whole 24-hour period on the day of admission or day of death, such day will be considered a patient day.

(10) "Provider" means a nursing facility or hospital that meets the provider participation requirements specified in ARM 37.88.1405.

(11) "Resident" means a person admitted to the provider's facility who has been present in the facility for at least one 24-hour period. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195; AMD, 2000 MAR p. 2036, Eff. 7/28/00.)

Rules 03 and 04 reserved

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37.88.1405 INSTITUTIONS FOR MENTAL DISEASES, PROVIDER PARTICIPATION REQUIREMENTS (1) An institution for mental diseases, as a condition of participation in the Montana medicaid program, under ARM 37.88.1401, 37.88.1402, 37.88.1405, 37.88.1406, 37.88.1410, 37.88.1411 and 37.88.1420 must be a provider that meets the following requirements:

(a) complies with the requirements set forth at ARM 37.40.306 for medicaid nursing facility service providers;

(b) has been determined by the department, in accordance with ARM 37.88.1402, to be an institution for mental diseases;

(c) complies with ARM 37.40.352 regarding utilization review and quality of care for nursing facilities; and

(d) enters into and maintains a written agreement with the department that specifies the respective responsibilities of the department and the provider including arrangements for:

(i) joint planning between the parties to the agreement;

(ii) development of alternative methods of care;

(iii) permission for immediate readmission to the institution when the recipient's need for readmission has been determined to be medically necessary;

(iv) access by the department to the recipient, the recipient's records and the facility;

(v) recording, reporting and exchanging medical and social information about recipients; and

(vi) other procedures necessary to carry out the agreement; or

(e) is a hospital which is devoted to the provision of inpatient psychiatric hospital care to adults. A publicly owned hospital devoted to the provision of inpatient psychiatric care to adults shall not be required to enter into and maintain a written agreement as provided in (1)(d). (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195; AMD, 2000 MAR p. 2036, Eff. 7/28/00.)

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37.88.1406 INSTITUTIONS FOR MENTAL DISEASES, INDIVIDUAL TREATMENT PLANS (1) Institutions for mental diseases providing services under ARM 37.88.1401, 37.88.1402, 37.88.1405, 37.88.1406, 37.88.1410, 37.88.1411 and 37.88.1420 must provide for and maintain recorded individual plans of treatment and care to ensure that institutional care maintains the recipient at, or restores the recipient to, the greatest possible degree of health and independent functioning. The plans must include:

(a) an initial review of the recipient's medical, psychiatric and social needs within 30 days after the date of admission;

(b) periodic review of the recipient's medical, psychiatric and social needs;

(c) a determination at least every 90 days of the recipient's need for continued institutional care and for alternative care arrangements;

(d) appropriate medical treatment in the institution; and

(e) appropriate social services. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195.)

Rules 07 through 09 reserved

37.88.1410 INSTITUTIONS FOR MENTAL DISEASES, REIMBURSEMENT

(1) The Montana medicaid program does not cover and will not reimburse for services provided in institutions for mental diseases, except:

(a) services provided to medicaid recipients ages 18 through 21 and 65 or over in hospitals devoted to the provision of inpatient psychiatric hospital care for adults; or

(b) as provided in ARM 37.88.1401, 37.88.1402, 37.88.1405, 37.88.1406, 37.88.1410, 37.88.1411 and 37.88.1420 for medicaid recipients age 65 or over receiving nursing facility services in a nursing facility that the department has determined to be an institution for mental diseases under ARM 37.88.1402.

(2) For nursing facility services provided to medicaid recipients age 65 years or over in an institution for mental diseases, the Montana medicaid program will pay a provider:

(a) for each patient day, an interim per diem rate, as specified in (3), minus the amount of the medicaid recipient's patient contribution; and

(b) additional reimbursement for separately billable items as provided in (4).

(3) The final per diem payment rate for:

(a) the Montana state hospital is $335; and

(b) the Montana mental health nursing care center at Lewistown is $150 for high acuity patients and $100 for low acuity patients.

(4) Separately billable items are those items specified in ARM 37.40.330 and are reimbursable by medicaid according to the provisions of ARM 37.40.330.

(5) For hospital services provided to medicaid recipients age 18 through 21 and 65 or over, the Montana medicaid program will pay hospitals devoted to the provision of inpatient psychiatric hospital care to adults an all-inclusive per diem rate which includes the cost of physician and dental services as well as the cost of the services listed in ARM 37.86.2902(2). (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195; AMD, 2000 MAR p. 2036, Eff. 7/28/00.)

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37.88.1411 INSTITUTIONS FOR MENTAL DISEASES, BILLING AND PAYMENT (1) Providers must bill for all services and supplies in accordance with the provisions of ARM 37.85.406. The department will pay a provider on a monthly basis the amount determined in accordance with these rules upon receipt of an appropriate billing which reports the number of patient days provided to authorized medicaid recipients during the billing period. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195.)

Rules 12 through 19 reserved

37.88.1420 INSTITUTIONS FOR MENTAL DISEASES, ADMINISTRATIVE REVIEW AND FAIR HEARING PROCEDURES (1) Providers may appeal adverse determinations by the department through the administrative review and fair hearing procedures specified in ARM 46.12.1268. (History: Sec. 2-4-201 and 53-6-113, MCA; IMP, Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 195.)